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ATTACHMENT F
RESPONSIBILITIES OF THE STATE

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Medicaid is a Federal- and State-funded health care program providing payment for reasonable and necessary medical care for persons meeting eligibility requirements. Each State administers its own program in accordance with Federal requirements. In Indiana, the Indiana Family and Social Services Administration (IFSSA), Office of Medicaid Policy and Planning (OMPP) administers the Medicaid program, which includes Hoosier Healthwise. The Hoosier Healthwise managed care program enrolls recipients of the Children's Health Insurance Program (CHIP) and certain Medicaid recipients. Other State agencies interface with OMPP in administering and managing the Hoosier Healthwise program.

1.0 The Indiana Family and Social Services Administration (IFSSA)

The IFSSA provides services for low-income individuals and families, children, senior citizens, people with mental illness, people with addictions and people with physical and developmental disabilities. As part of IFSSA, OMPP administers Indiana Health Coverage Programs (IHCP). Various divisions within IFSSA support OMPP in administering the IHCP. These are:

1.1 The Office of Medicaid Policy and Planning (OMPP)

This Office finances basic, cost-effective health care coverage for low-income residents of Indiana. Managed care programs include Hoosier Healthwise and *Medicaid Select*.

1.2 The Office of Children's Health Insurance Program (CHIP)

In the Balanced Budget Act of 1997, Congress allotted money to each state to develop a program to expand health coverage to uninsured children. Operating in coordination and cooperation with OMPP, the Office of the Children's Health Insurance Program (CHIP) is responsible for administering the CHIP program in Indiana. The Hoosier Healthwise program includes the CHIP population.

Indiana's CHIP program is built on the existing Medicaid program and uses the same eligibility determination and enrollment processes, provider networks and claims payment systems as the Hoosier Healthwise managed care program. The CHIP office contracts with a premium collection vendor. Additionally, State law requires the CHIP program to conduct and report the results of an annual evaluation of the CHIP program to the Legislature. The State delegates this evaluation to an independent contractor.

1.3 Division of Family and Children (DFC)

This Division administers programs for families and children focusing on prevention, early intervention, self-sufficiency and preservation. Programs include Temporary Assistance to Needy Families (TANF), food stamps, housing, child support, child protection, childcare, adoption, homeless services and job programs. This division supports OMPP by determining Medicaid and CHIP eligibility. The State transmits eligibility data, housed in the Indiana Client Eligibility System (ICES), to Indiana*AIM* daily.

1.4 Division of Mental Health and Addiction (DMHA)

This Division offers accessible, acceptable and effective mental health services, and drug and substance abuse services for Indiana residents. Services include advisory groups, crisis counseling, prevention activities, provider listings and State psychiatric hospitals.

1.5 Division of Disability, Aging and Rehabilitative Services (DDARS)

This Division offers people with disabilities and elderly Indiana residents with services that focus on supporting employment, independent living, and nutritional needs. This Division determines the eligibility for home- and community-based waivers for OMPP.

2.0 The Office of Medicaid Policy and Planning (OMPP)

OMPP is organized into six functional areas described below.

2.1 Program Operations: Managed Care

The managed care unit is responsible for planning, developing, designing and implementing all new and amended policies and initiatives pertaining to managed care. The Unit oversees all managed care contracts, develops appropriate contractual requirements and monitors all managed care reimbursement arrangements and systems implementation. While managed care organizations (MCOs) contract with both the OMPP and the CHIP Offices, the OMPP managed care unit is responsible for the administration of contracts procured through this RFP. The managed care unit works in collaboration with the CHIP Office. The OMPP managed care unit will award contracts to qualified MCOs, monitor contractor performance and perform quality assurance activities.

2.2 Indiana Chronic Disease Management Program (ICDMP)

The ICDMP unit administers the State's chronic disease management program for diseases such as congestive heart failure, asthma and diabetes. The ICDMP is a program for eligible members in Hoosier Healthwise and *Medicaid Select* that offers high and low level interventions to assist members in building self-management skills to manage their chronic illness(es).

2.3 Program Operations: Acute Care

The acute care unit is responsible for the Medicaid program's medical policy; prior authorization; fee-for-service (FFS) claims administration; IHCP provider relations; provider enrollment; compliance with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) standards; Surveillance and Utilization Review (SUR); Third-Party Liability (TPL); FFS pharmacy benefit management and FFS reimbursement rates. It also oversees several contractors and the management of the Indiana*AIM* system.

2.4 Data Management and Analysis

This unit is responsible for data management and analysis and budget forecasting. This unit oversees OMPP's actuarial contractor and works closely with OMPP staff to meet their data needs.

2.5 Program Operations: Long-Term Care

This unit is responsible for long-term care reimbursement; inspection and medical level-of-care determinations; monitoring institutional, hospice, home health reimbursement and audit activity; operational aspects of home- and community-based care; and waiver program management and

reporting. This unit is also responsible for the Medicaid for Employees with Disabilities program (i.e., the M.E.D. Works program). It allows working individuals with incomes too high for regular Medicaid to be eligible for health coverage within the *Medicaid Select* managed care program by paying a premium, or "buying-in" to the program.

2.6 Indiana Long-Term Care Insurance Program (ILTCIP)

This program is a partnership between the State of Indiana and private insurance companies that voluntarily agree to meet the ILTCIP's requirements with regard to new long-term care insurance policies. These long-term care insurance policies meet more stringent State requirements than other policies and place their purchasers under more favorable Medicaid eligibility rules. The ILTCIP sets standards for partnership policies, monitors compliance, coordinates efforts of the participating insurance companies and provides consumer education and information.

3.0 Managed Care Contractors

OMPP contracts with various entities in its administration and management of the Hoosier Healthwise program. These entities identified below act on behalf of the State in managing various functions and components of the Hoosier Healthwise program.

3.1 Managed Care Organizations (MCOs)

Managed care organizations (MCOs) are health maintenance organizations (HMOs) that will assume financial risk for developing and managing a health care plan and network that supports and administers covered services within Packages A, B and C of the Hoosier Healthwise program.

3.2 Fiscal Agent

The fiscal agent is the contractor responsible for Indiana*AIM*, the IHCP Medicaid Managed Information System (MMIS), and for managing all information systems related to the processing and reporting of enrollment, claims and utilization data for the IHCP. The fiscal agent is also responsible for conducting certain managed care activities as follows:

- Maintains eligibility records and sends member information to the MCO twice a month, including members' third-party liability resources
- Maintains all member and PMP enrollments and disenrollments
- Acts as a premium vendor for Hoosier Healthwise Package C premium payments
- Processes the shadow claims submitted by the MCOs, the claims for services submitted for Prime*Step* enrollees and claims for carved-out services provided to risk-based managed care (RBMC) members
- Pays the MCO maternity delivery 'kick' capitation upon receipt of appropriate and complete documentation of the maternity delivery (i.e., shadow claims); pays MCO monthly capitation based on member enrollment; and pays the primary care case management (PCCM) primary medical provider (PMP) monthly administration fee

- Participates in the regular status meeting with the enrollment broker and OMPP, and facilitates the managed care policy meeting

- Participates in the Quality Improvement Committee, Clinical Advisory Committee and Clinical Studies Work Group

- Facilitates the monthly technical meeting with all MCOs

3.3 Enrollment Broker/PCCM Administrator

The enrollment broker provides choice counseling to potential enrollees and is the contractor responsible for providing education and outreach to Hoosier Healthwise enrollees and for managing and maintaining the Hoosier Healthwise Helpline. Currently, the enrollment broker also acts as the Administrator of the Prime*Step* network. The Prime*Step* Administrator's duties include Prime*Step* PMP and member services, data maintenance and reporting and meeting participation.

In accordance with 42 CFR 438.6(d), the program is prohibited from discriminating against individuals eligible to enroll on the basis of race, color, national origin, health status or the need for health care services, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, health status or the need for health care services. A PMP may refuse a member assignment only if he or she does not feel medically qualified to accept the case. The enrollment broker facilitates the PMP selection for the member.

3.4 Monitoring Contractor

The MCO monitoring contractor is responsible for performing many support activities at the direction of OMPP, such as assisting OMPP with:

- Performing readiness reviews of contracted MCOs

- Reviewing and analyzing data submitted in MCO performance reports and maintaining the MCO Reporting Manual

- Facilitating the Clinical Studies and Quality Improvement Committee Meetings

- Conducting shadow claims validation activities

- Participating in the monthly Managed Care Policy meetings

- Compiling Health Plan Employer Data and Information Set (HEDIS®) data, providing technical assistance support in the production of HEDIS® data and producing the Hoosier Healthwise program-wide HEDIS® report

3.5 External Quality Review Organization (EQRO)

OMPP contracts with an independent external quality review organization (EQRO), in accordance with Federal requirements, 42 CFR 438 Subpart E. The EQRO conducts annual validation and compliance review activities, such as validation of required MCO performance

improvement projects, and validation of MCO performance measures reported to or calculated by the State and a compliance review of required standards for access to care, structure and operations and quality measurement and improvement.

3.6 Actuary

OMPP contracts with an actuary to develop the MCO capitation rates for Hoosier Healthwise. The actuary helps OMPP demonstrate the cost-effectiveness of the managed care program in waiver renewals. Attachment H of this RFP details the capitation rate setting. The actuary also produces the quarterly Capitation Rate Calculation Sheets (CRCS) for the PCCM population and for each MCO from the plan's encounter data.

3.7 Utilization Review Organization

OMPP contracts with a utilization review organization to administer medical policy, prior authorization and the surveillance and utilization review functions of the IHCP and the Hoosier Healthwise PCCM program. The MCO may attend the quarterly Medical Policy Meetings facilitated by this contractor.

3.8 Pharmacy Benefits Manager

OMPP contracts with a pharmacy benefits manager for IHCP. The pharmacy benefits manager processes prescription drug claims for FFS and PCCM, and maintains the Medicaid FFS and PCCM Preferred Drug List.

3.9 Indiana Chronic Disease Management Contractors

OMPP contracts with AmeriChoice, the Indiana Minority Health Coalition (IMHC), the Indiana Primary Health Care Association (IPHCA), the Indiana State Department of Health's Indiana Joint Asthma Coalition, and the Indiana University School of Medicine's Regenstrief Institute for Health Care to administer the Indiana Chronic Disease Management Program.

3.10 CHIP Package C Premium Collection Contractor

The CHIP Office contracts with an organization to collect premium payments from members eligible for benefits under CHIP Package C as well as to complete premium adjustments and submit reconciliation reports for CHIP Package C.

4.0 Activities of the State and Its Agents

4.1 Eligibility Determination

Through the IFFSA Division of Family and Children, the State is responsible for determining if persons are eligible for Medicaid benefits (405 IAC 2-1). See Attachment E of this RFP for populations eligible for or excluded from managed care.

Medicaid eligibility re-determination will occur no later than once every six months for Temporary Assistance to Needy Families (TANF) members and every 12 months for Pregnancy Medicaid, Children's Medicaid and Package C members. New and re-determined members have

the opportunity to choose a PMP in either the Prime*Step* or RBMC delivery system, if re-determination does not disqualify the member for eligibility.

Re-determination is generally a seamless process if no gaps in eligibility occur. When a break in the member's eligibility occurs, upon re-determination, the State's enrollment broker will instruct the individual to participate in an educational session and re-select a PMP.

4.2 Member Enrollment and Linkage to PMP

OMPP is responsible for identifying and enrolling Medicaid and CHIP recipients into Hoosier Healthwise managed care when the recipient's eligibility determination qualifies him/her for the Hoosier Healthwise program. Attachment E of this RFP discusses eligible and excluded populations. Enrollment into managed care involves the linking of the member to an appropriate PMP. After a member to PMP linkage occurs, either by self-selection or auto-assignment, the fiscal agent informs the member by mail of the member's PMP and plan enrollment.

4.2.1 Member Selection of PMP

The State's enrollment broker employs Benefit Advocates (BAs) who present Hoosier Healthwise managed care information to potential enrollees and assists them in selecting a PMP. The BAs educate enrollees about the benefits of primary and preventive care, the differences between the health plan options available to the potential enrollee and the importance of choosing a PMP and establishing the PMP and member relationship.

The BAs also facilitate the enrollment process with informative brochures, MCO promotional information and videos as part of the initial enrollment or redetermination process. During the enrollment process, the BAs provide nearly all Hoosier Healthwise enrollees either a face-to-face or telephone interview during which they are educated about:

- The usefulness of primary and preventive care
- The differences between the managed care plans available in the members' county of residence
- The PMPs and providers available in the enrollee's county of residence
- The importance of choosing a PMP and having a medical home
- The appropriate use of the emergency room

The BAs provide potential enrollees with a list of the PMPs and specialists in the member's county of residence and a description of the health plan options available to the member in Hoosier Healthwise. The member has 30 calendar days from the date he/she becomes eligible or is redetermined to be eligible for Hoosier Healthwise to choose a PMP and health plan option. If the potential enrollee does not make a selection, OMPP will auto-assign the person to an appropriate PMP. Auto-assignment is discussed below in Section 4.2.2, Auto-Assignment Process.

Unlike enrollment procedures used by other states' Medicaid managed care programs, individuals eligible for Hoosier Healthwise select a PMP, as opposed to a managed care plan. The State's enrollment broker enrolls the member into the plan that contracts with that PMP. This process serves to emphasize the importance of establishing and maintaining a relationship with a PMP of the member's choice.

The State's enrollment policies and procedures prohibit discriminating against individuals eligible to enroll on the basis of race, color, national origin, health status or the need for health care services, and the State will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, health status or the need for health care services, in accordance with 42 CFR 438.6(d). The MCO may neither terminate enrollment nor encourage a member to disenroll because of a member's health care needs or a change in a member's health care status. Further, a member's health care utilization patterns may not serve as the basis for disenrollment from the MCO. A PMP may refuse a member assignment only if he or she does not feel medically qualified to accept the case. In those cases, with OMPP's approval, the MCO works with the enrollment broker to facilitate another PMP selection for the member within the MCO's network.

4.2.2 Auto-Assignment Process

If the enrollee does not choose a PMP within 30 calendar days of eligibility determination, Indiana*AIM* will assign a PMP to the member through an auto-assignment process that complies with 42 CFR 438.52(f). This process automatically links an appropriate PMP to an enrollee if he/she fails to select a PMP.

The DFC uses ICES, the State's management information system (i.e., database), to maintain member eligibility records. The State transmits eligibility data, housed in ICES, daily to Indiana*AIM*. The Indiana*AIM* system identifies eligible Hoosier Healthwise managed care members who have not selected their PMP within 30 calendar days of being determined eligible for Hoosier Healthwise and considers several factors when linking a member and a PMP, including previous PMP and managed care plan relationships. The Hoosier Healthwise auto-assignment process can review only a current or previous member-PMP linkage within the Hoosier Healthwise program. This means that the auto-assignment logic will not identify a prior member-physician relationship that may have existed before the member may have had with a Hoosier Healthwise physician prior to enrolled in the Hoosier Healthwise program.

If the member does not make a selection 30 calendar days from the date re-determination occurs, the State's auto-assignment process will re-enroll the member automatically in Hoosier Healthwise. If the gap in eligibility is less than a year, the member will likely be assigned to his/her previous PMP.

The MCO Policies and Procedures Manual describes the auto-assignment logic.

4.2.3 Enrollment of Newborns

The Hoosier Healthwise program encourages pregnant women, whether in Package A or B, to select a doctor for their child prior to the birth of their baby. If the woman is enrolled in Prime*Step* or FFS on the newborn's date of birth, and makes a pre-birth PMP selection for the

baby, the effective date with the PMP is the 1st or 15th day of the month, dependent on when the State establishes the newborn's eligibility in the Indiana*AIM* system. These same effective dates apply if there is no pre-selection on file for women enrolled in Prime*Step* or FFS at the time of delivery.

If the woman is enrolled in an MCO on the newborn's date of birth and does not make a pre-birth selection, the State auto-assigns the baby retroactively to the baby's date of birth to an appropriate PMP in the woman's MCO, unless there is no available PMP in the MCO. If the woman is enrolled in an MCO and pre-selects a PMP in the same plan, the baby is assigned to that PMP retroactively to the baby's date of birth.

If a Package A or B woman is enrolled in an MCO, and selects a Prime*Step* PMP for her newborn, the State first auto-assigns the newborn retroactively back to date of birth to an appropriate PMP in the woman's MCO once the State establishes the newborn's eligibility. The State enters the Prime*Step* PMP pre-selection as a future PMP change. If there is no appropriate PMP available in the MCO, the baby will be in FFS initially until the pre-selection is effective. Babies born to Package A or B women are automatically eligible for Medicaid benefits for one year from the baby's date of birth.

Newborns of women in Package C are not automatically eligible for the benefits. If a woman who is enrolled in Package C becomes pregnant, she must submit a CHIP application for her newborn. The State must determine the newborn eligible for the CHIP program, and the member must pay the premium before the newborn is enrolled in the program. Once the State receives the first premium payment, the newborn is eligible for benefits. The State will assign the newborn prospectively to a PMP either by selection or auto-assignment.

The MCO Policies and Procedures Manual available with this RFP provides more information regarding the Pre-Birth Selection and PMP selection and change process.

4.2.4 Enrollment Rosters

OMPP's fiscal agent notifies each MCO of all members enrolled in the MCO's network. The fiscal agent generates semi-monthly MCO Member Enrollment Rosters and PMP Enrollment Rosters using information obtained from the DFC's ICES transmissions, PMP assignments entered into the Indiana*AIM* system by the enrollment broker during member enrollment and the auto-assignment process. The MCO Member Enrollment Rosters provide the MCO with a detailed listing of all members for whom the MCO is or has been responsible (i.e., new, continuing and terminated enrollees and newborns) and identifies each enrollee's benefit package (i.e., Package A, B or C). The enrollment roster also identifies deleted enrollees who appeared as eligible members on the previous roster, but whose eligibility terminated prior to the actual effective date with the MCO.

Publishing lags may result in eligibility discrepancies in the enrollment rosters. The MCO and rendering provider are responsible for verifying eligibility. If an MCO receives either eligibility information or capitation for a member, the MCO is financially responsible for the member. The State's fiscal agent's eligibility verification systems, which are updated daily, should be used in the event of any discrepancies. The MCO discovering eligibility/capitation discrepancies should notify OMPP or the fiscal agent within 30 calendar days of discovering

the discrepancy and no more than 90 calendar days after OMPP delivers the eligibility records.

On the day the rosters are produced, the enrollment roster member data is current. The fiscal agent provides member enrollments to the MCO in two segments each month:

- On the 26th day of the month, the fiscal agent provides the MCO with managed care enrollments entered into the Indiana*AIM* system from the 11th through the 25th days of the month. This roster lists members whose eligibility is effective on the 1st day of the following month.

- On the 11th day of the month, the fiscal agent provides the MCO with managed care enrollments entered into the Indiana*AIM* system from the 26th day of the previous month through the 10th day of the current month. This roster lists members whose eligibility is effective on the 15th day of the current month.

Refer to the MCO Policies and Procedures Manual for detail about the enrollment roster process.

4.2.5 MCO Member Enrollment Limitations

On a county-by-county basis, the State will monitor MCO member enrollment in the mandatory RBMC counties monthly. The State may limit member enrollment in the MCO in a particular county (or counties) to ensure adequate member choice among participating Hoosier Healthwise MCOs, thereby protecting the mandatory status of the county. However, the State does not intend to restrict member selections of PMPs or disrupt a previous member/PMP relationship.

The State will also monitor the actual panel sizes of each of the MCO's PMPs. The State will notify the MCO in advance of implementing member enrollment limitations. The State may retard MCO member enrollment growth by one or more of the following methods:

- Suspending MCO's PMP contracting activities
- Excluding the MCO from receiving default auto-assignment
- Excluding the MCO from receiving previous MCO auto-assignment

The State will evaluate MCO member enrollment each month to determine when any of the member limitations may be lifted.

4.3 Member Disenrollment

4.3.1 Change of Member Linkage to PMP

The member can disenroll from the MCO network at any time by contacting the enrollment broker and requesting a change in his/her PMP assignment. The Hoosier Healthwise enrollment broker receives the requests for disenrollment for processing, tracking and monitoring purposes. The enrollment broker and OMPP will monitor members who switch PMPs frequently and will discourage such activity through member education and related activities.

The MCO must comply with all Federal enrollment and disenrollment requirements stated in 42 CFR Section 438.56, as applicable to the Hoosier Healthwise program.

Members may change PMPs at any time. However, members should be encouraged to establish and maintain a relationship with their PMPs. The MCO may take member requests for PMP changes within its own network; however, the MCO must notify the enrollment broker for the change to be processed and become effective. If the member desires a change to a PMP in another plan, the MCO must transfer the member call to the enrollment broker to make this change. The MCO Policies and Procedures Manual available with this RFP provides more information regarding the Pre-Birth Selection and PMP selection and change process.

In accordance with 42 CFR 438.56(d)(2), the following are typical reasons for members to request to disenroll from the MCO:

- The member moves out of the MCO's service area.

- The MCO does not, because of moral or religious objections, cover the service the member seeks.

- The member needs related services (for example a Cesarean section and a tubal ligation) performed at the same time. These related services are not all available within the network but the member's PMP or another provider determines that receiving the services separately would subject the member to unnecessary risk.

- Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract or lack of access to providers experienced in dealing with the member's health care needs.

The PMP may request member disenrollments in accordance with OMPP guidelines. The PMP can submit a disenrollment request to the enrollment broker for the following reasons:

- Missed appointments
- Member fraud
- Uncooperative or disruptive behavior from the member or the member’s family
- Medical needs could be better met by a different PMP
- Breakdown in physician and patient relationship
- Member accessing care from providers other than the selected or assigned PMP
- Member insists on medically unnecessary medications

To ensure that the PMP does not request member disenrollment for reasons not permitted, the PMP must provide evidence to the enrollment broker that one of the acceptable terms for disenrollment exists before the enrollment broker can disenroll the member from the PMP. The MCO Policies and Procedures Manual provides more information regarding the PMP Request for Member Transfer.

OMPP shall consider all relevant factors in making its decision, and OMPP's decision regarding disenrollment shall be final.

4.3.2 Disenrollment From Hoosier Healthwise

Under very limited conditions and in accordance with OMPP guidelines, the enrollment broker will approve a member disenrollment from the Hoosier Healthwise managed care program entirely. The enrollment broker receives oral or written requests for disenrollment and documents, tracks and monitors these requests for OMPP. OMPP has the ultimate authority for allowing eligible members to disenroll from the program. OMPP and the enrollment broker discourage members from disenrolling and switching programs frequently. In accordance with 42 CFR 438.56(d)(3), the disenrollment will automatically be considered approved within the timeframe stated in the Federal regulation. For more information regarding the procedures for a plan/PMP change or member disenrollment, refer to the MCO Policies and Procedures Manual.

If premium payments are delinquent, OMPP will disenroll a child from the Package C Children's Health Insurance Program after a 60-day grace period. However, upon payment of any delinquent premiums from the past 24 months, OMPP will reinstate these children and re-assign them to their previous PMP (if appropriate). If reassignment to the child's previous PMP is not appropriate, the child will be auto-assigned to an appropriate PMP. The State pays providers' claims during the Package C member's retro-eligibility period through the FFS delivery system.

4.4 Provider Enrollment and Disenrollment

The State considers all providers as eligible to participate in Hoosier Healthwise when the provider enrolls with the IHCP. The State allows physicians to contract as PMPs in either the Prime*Step* program or one MCO plan. However, specialists and ancillary providers may participate in Prime*Step* and contract in all MCO networks. Additionally, a physician who is a PMP with one MCO plan may contract as a specialist with another MCO plan.

In the event a PMP disenrolls from either the Prime*Step* program or any MCO and re-enrolls with a different Hoosier Healthwise plan, the State will generally maintain the linkage with the members assigned to that PMP. A member may contact the enrollment broker to request a PMP change in order to remain with the original plan. The MCO Policies and Procedures Manual provides more information.

4.5 Ongoing MCO Monitoring

OMPP and its MCO monitoring contractor review and monitor MCO performance on a regular basis and identify non-compliance with program requirements and performance standards outlined in this RFP. OMPP conducts monitoring activities through site visits, document review, review of performance data and analysis of shadow claims data. In addition, the CHIP Office monitors the access, quality and cost-effectiveness of services provided to the CHIP enrollees.

OMPP reserves the right to change or modify the reporting requirements, evaluation instruments and enforcement policies, as necessary, at any time during the contract period with sufficient

notice to the MCO resulting from its monitoring activities or changes in Federal or State requirements.

OMPP, or duly authorized agents of the State or Federal government, reserves the right to inspect, audit, monitor or otherwise evaluate the performance of the MCO or its subcontractors during normal business hours, at the MCO's or its subcontractors premises.

In addition, OMPP complies with the external quality review regulations for monitoring managed care organizations set forth in 42 CFR 438.350.

4.6 Evaluating MCO Solvency

The Indiana Department of Insurance maintains the primary responsibility for monitoring the MCO's solvency and monitors the MCO's financial status in accordance with IC 27-13.

In addition, OMPP monitors the MCO's solvency status in accordance with Federal regulations described in 42 CFR 438.116 by requiring the submission of various financial data for review.

4.7 Making Payments to the MCO

OMPP pays MCOs participating in Hoosier Healthwise a monthly capitation payment for each enrolled member and, upon submission of proper shadow claim data, a kick payment for maternity deliveries. The MCO Policies and Procedures Manual discusses the capitation payment process, Electronic Funds Transfer (EFT) and other related issues. Attachment H provides information on the capitation rates.

Recognizing that service utilization may vary among geographic areas, OMPP uses the three regions – North, Central and South – for capitation rate setting. However, OMPP issues only one statewide contract to the MCO. OMPP encourages the MCO to develop a network throughout the State and requires the MCO to develop a network in all mandatory RBMC Counties. Attachment G of this RFP contains a map of the State with the three geographic regions and the mandatory RBMC counties.